

**PATIENT INFORMATION**

**The information provided in this form is vitally important in the planning of your surgical care. Omission of complete and accurate information to the physician could result in the delay or cancellation of your surgery as well as jeopardize the ability of the physician to provide the best possible care.**

NAME: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_

FIRST MIDDLE LAST  
SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_ MALE/FEMALE RACE: \_\_\_\_\_ MARITAL STATUS: S M W D

ADDRESS: \_\_\_\_\_  
STREET APT# CITY STATE ZIP

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP

**PRIMARY INSURANCE INFORMATION:** Please include the front and back copy of your insurance card(s).

INSURANCE PROVIDER: \_\_\_\_\_ PROVIDER PHONE #: \_\_\_\_\_

MEMBER ID #: \_\_\_\_\_ GROUP#: \_\_\_\_\_

**POLICY HOLDER'S INFORMATION (If different than pt.):**

NAME: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_-\_\_\_\_ ADDRESS: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION:**

INSURANCE PROVIDER: \_\_\_\_\_ PROVIDER PHONE #: (\_\_\_\_) \_\_\_\_-\_\_\_\_

MEMBER ID #: \_\_\_\_\_ GROUP#: \_\_\_\_\_

**POLICY HOLDER'S INFORMATION:** NAME: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYER: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_-\_\_\_\_ ADDRESS: \_\_\_\_\_

**ARE YOU RECEIVING DISABILITY BENEFITS?**  No  Yes IF YES, LIST REASON(S):

\_\_\_\_\_  
\_\_\_\_\_

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**EMERGENCY CONTACT:** \_\_\_\_\_ HOME PHONE #: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_  
MOBILE #: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_  
RELATIONSHIP: \_\_\_\_\_

**TRAVEL COMPANION OR TRANSPORT SERVICE FOR OUT-OF-TOWN PATIENTS ONLY**

For your safety, the facility may not allow you to leave alone or drive yourself for any procedure requiring anesthesia. If you do not have an adult over the age of 18 to stay with you, the facility may cancel your surgery.

HSS is not responsible for travel expenses if the surgery is cancelled or rescheduled for any reason.

NAME: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_  
\_\_\_\_\_

**PRIMARY CARE PHYSICIAN:** \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_  
\_\_\_\_\_

ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP

**HOW DID YOU HEAR ABOUT DR. MARVIN?**

- Web Search \_\_\_\_\_  Social Media \_\_\_\_\_  Friend/Family \_\_\_\_\_  
 MD Referral (name) \_\_\_\_\_ Phone # \_\_\_\_\_  
 A patient of Dr. Marvin (name) \_\_\_\_\_

**WHAT IS THE PROCEDURE OF INTEREST?**

- \_\_\_\_ Endoscopic Sleeve Gastroplasty      \_\_\_\_ Gastric Bypass (Roux-en-y)  
\_\_\_\_ Dual Gastric Balloons      \_\_\_\_ Laparoscopic Sleeve Gastrectomy  
\_\_\_\_ Gastric Lap-Band      \_\_\_\_ Unsure

\_\_\_\_\_  
SIGNATURE\_\_\_\_\_  
DATE\_\_\_\_\_  
PARENT SIGNATURE (if patient under 18 years of age)      DATE

## COMPLETE MEDICAL HISTORY

What is your current weight? \_\_\_\_\_ LBS                      What is your current height? \_\_\_\_\_ FT \_\_\_\_\_ IN

Have you had previous weight loss surgery?     No     Yes

If Yes, Please provide following information.

Name of Surgeon \_\_\_\_\_ Surgery date \_\_\_\_\_ Procedure performed \_\_\_\_\_

List any medical **problems** you have for which you have seen a doctor or been **hospitalized**.

ILLNESS	DATE	TREATMENT	OUTCOME

- |  |  |
|--|--|
| Have you been diagnosed or treated for high blood pressure?                          | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you been diagnosed or treated for diabetes?                                     | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you have high blood cholesterol?  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you have high blood fats or triglycerides?  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever had a Heart Attack?  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you had an Irregular Heartbeat (arrhythmia)?                                    | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you had stents placed in your heart arteries?                                   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever been diagnosed with asthma?  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you been diagnosed or treated for Sleep Apnea?                                  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you sleep with a CPAP or BiPAP machine?   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you been diagnosed or treated for heartburn or gastro esophageal reflux (GERD)? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever had stomach ulcers?  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever had blood clots in your leg veins?                                     | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever had a blood clot to the lung (pulmonary embolus or PE)                 | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you been diagnosed with Polycystic Ovarian Syndrome (PCOS)?                     | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you had problems with infertility?  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you have irregular menstruation?  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you been treated for Arthritis or Joint Pain?                                   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you been treated for Back Pain or Sciatica?                                     | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever been diagnosed or treated for Gout?                                    | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Are you ever incontinent of urine when coughing or straining?                        | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever been anemic?   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever had iron deficiency or taken iron?                                     | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever been diagnosed with Hypothyroidism?                                    | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever had thyroid surgery?   | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you take thyroid replacement medication?  | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Print Patient Name \_\_\_\_\_

**Have any of your close relatives been treated for the following:**

- High blood pressure?  No  Yes  
 High Cholesterol?  No  Yes  
 Diabetes?  No  Yes  
 Heart Attack or Heart Disease?  No  Yes  
 Stroke?  No  Yes

**List all surgeries and specify if done open or laparoscopic.**

SURGERY	DATE	REASON	OPEN OR LAP

- Have you had your gallbladder removed?  No  Yes  
 Have you had a hysterectomy?  No  Yes  
 Have you had a tubal ligation or had your "tubes tied"?  No  Yes  
 Have you had a hiatal hernia repair or Nissen Fundoplication?  No  Yes  
 Have you had any operation on your stomach?  No  Yes  
 Have you had a repair of an abdominal wall hernia?  No  Yes

**List all current medications, including prescriptions, vitamins, over-the-counter, and intermittently used drugs. PLEASE PRINT.**

NAME	STRENGTH	FREQUENCY	PURPOSE	STARTED	DAILY?	AS NEEDED

- Do you take aspirin?  No  Yes  
 Do you take Plavix (Clopidogrel)?  No  Yes  
 Do you take Coumadin or Warfarin?  No  Yes  
 Do you take Plaquinel or Methotrexate?  No  Yes  
 Do you take any type of platelet inhibitor (i.e. effient or persantine)?  No  Yes  
 Do you take any oral or injectable blood thinner?  No  Yes  
 Do you take Prednisone or Dexamethasone?  No  Yes

**List any allergies to medication and explain reactions you experienced.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you get chest pain when exercising?  No  Yes  
 Do you get short of breath at rest?  No  Yes  
 Do you experience irregular or excessively strong heartbeats?  No  Yes  
 Do you sleep lying flat?  No  Yes  
 Do you wake up at night short of breath?  No  Yes  
 Have you had any blackouts?  No  Yes  
 Do you get swollen ankles?  No  Yes  
 Have you had easy or excessive bleeding from surgery or minor injuries?  No  Yes  
 Have you had easy bruising?  No  Yes  
 Do you have heavy periods?  No  Yes  
 Are you still having periods?  No  Yes

Do you drink alcohol?  No  Yes  
 How much alcohol do you drink a week? \_\_\_\_\_  
 Do you use recreational drugs?  No  Yes  
 Have you ever smoked tobacco products?  No  Yes  
 If yes, how many years? \_\_\_\_\_  
 How many packages of Cigarettes a day? \_\_\_\_\_

Have you been diagnosed or treated for depression?  No  Yes  
 Have you been diagnosed or treated for Bipolar Disorder?  No  Yes  
 Have you been diagnosed or treated for Schizophrenia?  No  Yes  
 Have you ever received Psychiatric treatment?  No  Yes  
 What was the diagnosis? \_\_\_\_\_  
 When was your last treatment? \_\_\_\_\_  
 Who were you treated by? Psychiatrist, Psychologist, or Physician (circle one)  
 Physicians Name \_\_\_\_\_  
 Physicians Telephone \_\_\_\_\_  
 Physicians E-mail \_\_\_\_\_

Does your religion prohibit you from receiving blood products?  No  Yes  
**If you answered yes, would you consent to any of the following?**  
 Autotransfusion with your own blood (i.e. sell saver)  No  Yes  
 IV infusion of Albumin  No  Yes  
 Transfusion of Platelets  No  Yes  
 Transfusion of Plasma  No  Yes

### Sleep Apnea Self-Test

The quiz is designed to alert you to any problems resulting from poor sleep. Please answer the questions below. If you have had any symptoms in the past year, mark the box below and add up the total.

- (20) \_\_\_\_\_ 1. I have been told that I snore or I know that I snore.
- (-50) \_\_\_\_\_ 2. I definitely do not snore.
- (10) \_\_\_\_\_ 3. I have been told that I stop breathing when I sleep.
- (10) \_\_\_\_\_ 4. I wake up choking.
- (5) \_\_\_\_\_ 5. I sweat excessively at night.
- (-5) \_\_\_\_\_ 6. (If female and above is true) I have hot flashes related to my cycle.
- (2) \_\_\_\_\_ 7. I am tired and sleepy during the day even after 8 hours of sleep.
- (2) \_\_\_\_\_ 8. I wake up tired and unrested.
- (10) \_\_\_\_\_ 9. I suddenly wake up unable to breath.
- (5) \_\_\_\_\_ 10. I have fallen asleep while driving.
- (5) \_\_\_\_\_ 11. I am a restless sleeper (toss and turn a lot).
- (20) \_\_\_\_\_ 12. My neck circumference is more than 17 inches. (Ask office staff to measure if unknown)
- (5) \_\_\_\_\_ 13. I frequently have morning headaches.

\_\_\_\_\_ Total (more than 30 points suggests that you have SLEEP APNEA.)

### DIETARY HISTORY

Medically Supervised Diet Programs  
Check All that Apply

**M.D. Name** \_\_\_\_\_

**Office Phone** \_\_\_\_\_

- Medi-Fast
- Opti-Fast
- Mayo Clinic
- Physician or Registered Dietician Specific Diet Program

Shots:  B-6

B-12

Other

Pills:  Lasix (diuretic)

Xenical

Meridia

Other \_\_\_\_\_

**NON M.D. SUPERVISED**

- Weight Watchers
- Nutri-Systems
- Jenny Craig
- Diet Center

Print Patient Name \_\_\_\_\_

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**AUTHORIZATION FORM  
FOR RELEASE OF PROTECTED HEALTH INFORMATION**

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By signing this form, I authorize Dr. Robert G. Marvin to use and disclose the protected health information described below regarding my case for medical or financial purposes.

Patient Name: \_\_\_\_\_

Social Security: \_\_\_\_\_ D.O.B \_\_\_\_\_

Name (if different from patient): \_\_\_\_\_

Phone: \_\_\_\_\_ Work: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

The type of health information you may release subject to this authorization is as follows:

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**Non-Medical Individuals (Family/Friends) I authorize my Protected Health Information to are as follows:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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**Release my protected health information to the following person(s)/ entity:**

**Houston Surgical Specialists  
6330 West Loop South Ste. 610  
Bellaire, TX 77401  
Office: 713-993-7124  
Fax: 713-963-0476**

**HIV / AIDS:** I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical record.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE USE THIS FORM AS A TEMPLATE FOR YOUR INSURANCE CARD**

**PROVIDE A FRONT AND BACK COPY**

**THEY MUST BE READABLE**

Front Copy

Back Copy